Minutes of the Special Meeting of the Finance Committee of the Board of Directors of the Cook County Health and Hospitals System held Monday, May 17, 2021 at the hour of 10:00 A.M. This meeting was held by remote means only, in compliance with the Illinois Open Meetings Act.

I. **Attendance/Call to Order**

Chair Reiter called the meeting to order.

Present: Chair Robert G. Reiter, Jr. and Directors Hon. Dennis Deer, LCPC, CCFC; Joseph M. Harrington; David Ernesto Munar; and Director Otis L. Story, Sr. (5)

Board Chair M. Hill Hammock (ex officio) and Directors Robert Currie; Mary Driscoll, RN, MPH; Raul Garza; Ada Mary Gugenheim; and Mike Koetting

Absent: None (0)

Additional attendees and/or presenters were:

Yvonne Collins, MD – Chief Medical Officer, Health Plan Services
Aaron Galeener – Interim Chief Executive Officer, CountyCare/Health Plan Services
Andrea McGlynn – Director of Clinical Services, CountyCare
Kent Ray – Associate General Counsel
Israel Rocha, Jr. – Chief Executive Officer
Deborah Santana – Secretary to the Board

The next regular meeting of the Finance Committee is scheduled for Thursday, May 20, 2021 at 9:00 A.M.

II. **Electronically Submitted Public Speaker Testimony** (Attachment #1)

The Secretary read the following public testimony that was submitted into the record:

1. Erin Serrano Social Work Care Coordinator
2. Joyce Klein Social Work Care Coordinator
3. Barrie Newman TOC Social Work Care Coordinator

III. **Recommendations, Discussion/Information Items**

A. **Report on Care Management**

- CountyCare Health Plan / Managed Care Model (Attachment #2)
- Illinois Medicare-Medicaid Alignment Initiative (MMAI) Strategy (not presented/reviewed)

The following individuals provided an overview of the presentation on the above subjects: Aaron Galeener, Interim Chief Executive Officer, CountyCare/Health Plan Services; Dr. Yvonne Collins, Chief Medical Officer, Health Plan Services; and Andrea McGlynn, Director of Clinical Services, CountyCare. The Committee members reviewed and discussed the information.
III. Recommendations, Discussion/Information Items

A. Report on Care Management (continued)

The presentation contained information on the following subjects:

◊ Medicaid Services
◊ Care Coordination (CC) / Care Management (CM) program levels, services and process
◊ CountyCare CC/CM partners and teams
◊ Metrics and outcomes
◊ Opportunities for synergy and innovation

During the review and discussion of the information, the following questions and requests for further information were made:

- Prepare breakdown / summary report of the care coordination contracts, to include category of contract, amount of funding attached to the contract, original contract date, and whether the contract has had extensions.
- What is the actual distribution of in-house staff between contracted and employed staff?
- Show how systems will relate to each other.
- Show whether services are staffed internally or externally.
- Provide a few case examples related to the real world - who does what, why, where, when.
- Provide examples of when something didn’t happen as planned, and how the matter was fixed/resolved.

Chair Reiter noted that, as the questions and requests have flowed during the meeting, what is now being requested has now evolved into a white paper on mapping out the various contracts. Director Driscoll will be on the Board until the end of June; because she was the one who initially requested that this subject be discussed, he would like to have the white paper available before she leaves the Board. He requested that it be prepared and disseminated, if possible, in time for the June 17th Finance Committee Meeting. Israel Rocha, Jr., Chief Executive Officer, responded that he will work with the team to do their very best; they will work on outlines and examples, but he is not sure if he can commit to providing the entire white paper by then.

IV. Adjourn

As the agenda was exhausted, Chair Reiter declared the meeting ADJOURNED.

Respectfully submitted,
Finance Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXX
Robert G. Reiter, Jr., Chair
Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Follow-up/Requests

Follow-up: White paper to be prepared addressing the questions/requests for information listed on Page 2.
CountyCare Update
Care Management & Care Coordination (CC/CM) Model

Prepared for: CCH Board of Directors

Yvonne Collins, MD
Chief Medical Officer, CountyCare
May 17, 2021
Care Coordination & Care Management Overview

I. Medicaid services
II. CC/CM program levels, services & process
III. CountyCare CC/CM partners & teams
IV. Metrics and outcomes
V. Opportunities for synergy & innovation
Care Coordination & Care Management
Overview

I. Medicaid services
II. CC/CM program levels, services & process
III. CountyCare CC/CM partners & teams
IV. Metrics and outcomes
V. Opportunities for synergy & innovation
Service Package Benefits (SP1)

**SP1 benefits** are all granted to the enrollee as part of their basic benefit coverage for under Medicaid for LTSS members and Non-LTSS members.

**Inpatient care** such as emergency room, admission to hospital for medical or behavioral health care in rehabilitation, subacute.

**Outpatient care** such as visits, labs, tests, procedures, skilled home care aka Home Health Care – short term after hospital stay, hospice Care.

**Pharmacy benefits** including retail and specialty medications, prescription, mail order delivery and adherence programs.

**Other benefits** including dental, vision, medical non-urgent and urgent transportation, durable medical supplies.
Service Package Benefits (SP2)

**HCBS** Home and Community Based Services (Waiver Services) – alternatives to long-term care

**LTC** Long Term Care in nursing facilities or specialized mental health rehabilitation facilities

**LTSS** Long Term Services and Supports (HCBS + LTC)

**MLTSS** Managed Long Term Services and Supports (HCBS + LTC for Medicare-Medicaid “dual eligible” population)
HCBS Waiver Criteria & Covered Services

Waiver Programs (5) under HealthChoice Illinois MCOs

General Criteria
- At risk of nursing facility placement as measured by the Determination of Need (DON) Assessment
- Estimated cost of community based care is less than the estimated cost for institutional care

Waivers/specific criteria
- Aging Waiver (age 60+)
- Persons with Disabilities (under 60 at time of application)
- Persons with HIV/AIDS (of any age)
- Persons with Brain Injury (of any age)
- SLF Waiver (persons age 22-64 who have a physical disability per SSA or persons age 65+)

<table>
<thead>
<tr>
<th>Services</th>
<th>Aging Waiver</th>
<th>Disability Waiver</th>
<th>HIV/AIDS Waiver</th>
<th>Brain Injury Waiver</th>
<th>Supportive Living Facility Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Service</td>
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<td>✓</td>
<td>✓</td>
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<td>Adult Day Service Transportation</td>
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<td>Assisted Living</td>
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<td>Behavioral Services</td>
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<td>Day Habilitation</td>
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<td>Homemaker</td>
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<tr>
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<tr>
<td>Nursing, Skilled</td>
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<td>Personal Assistant</td>
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<td>Personal Emergency Response System</td>
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<td>Physical Therapy</td>
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<td>Prevocational Services</td>
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<td>Respite</td>
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<tr>
<td>Speech Therapy</td>
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<td></td>
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<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td>✓</td>
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<tr>
<td>Supported Employment</td>
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<td>✓</td>
</tr>
</tbody>
</table>
I. Medicaid services
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Complex Care Management & Care Coordination
Services and Member Populations

**Services**
- Assigned to licensed care coordinator (nurse, social worker, counselor)
  - Caseload ratios set by HFS by risk level
- Program begins with comprehensive assessment
- Assessment guides individual plan of care with goals, actions, monthly review, quarterly updates
- Plan of care shared with interdisciplinary care team members, care conferencing
- Scheduled contacts, including face-to-face
- Medication reconciliation

- Health risk screens for new and all enrollees
- Resources and referrals for identified risks
- Support to make/attend health and social service appointments, especially to close care gaps (HEDIS)
- Support when discharging from hospital (transition of care)
- Problem-solving support (e.g., finding a specific service, utilizing a covered benefit)
  - Caseload ratios at discretion of MCO to achieve goals

**Members**
- <15% of total membership
  - Recipients of Home and Community Based Services (required participation)
  - Residents in Long-Term Care
  - High and Moderate risk members
  - Pregnant women
  - Any member may request CCM

- Majority of membership
  - Members listed above who decline to enroll/participate in the program
  - Low risk members
Care Management Process

1. New members enter CountyCare
   - New members are risk stratified through health risk screening (high, moderate, low)

2. High and moderate risk members, pregnant members, or member request
   - Receive comprehensive health risk assessment
   - Offered Care Management

3. Members enroll in Care Management Program
   - Members receive ongoing timely care management outreach, including contacts, care plan reviews and updates, annual reassessment
   - Member is discharged from CM if Care Plan goals achieved or clinically appropriate

Members may opt out, become unable to reach, or be reengaged at any point in process, triggered primarily by changes in condition detected by referrals or health data.
HFS Contractual Requirements
Complex Care Management & Care Coordination

Services
• All members
  – Initial health risk screen/assessment within 60 days of enrollment
  – Ongoing monitoring for changes in condition for referral to complex care management
  – Problem solving support, care gap closures, and other contracted care coordination services as requested and as need identified

• High and moderate risk members & (M)LTSS members
  – Assessment and care plan within 90 days of stratification to high or moderate risk
  – Care plan review every 30 days (high risk) or 90 days (moderate risk)
  – Member contact with care coordinator every 90 days; face-to-face every six months
  – Increased contact and service plan requirements for (M)LTSS members, varies by program

Risk Stratification
  – FHP & ACA 2% high risk
  – ICP 5% high risk, 20% high plus moderate risk
  – SNC 20% high risk, 40% high plus moderate risk
  – (M)LTSS 20% high risk, 90% high plus moderate risk

Maximum Staffing ratios for members in Complex Care Management Program
  – HIV/TBI waiver members 1:30
  – High risk 1:75
  – Moderate risk 1:150
  – Low risk 1:600
Transitions of Care

Process
• Facilitate efficient and effective transitions of care
• Integrate resources of the member/family, treatment providers and health plan
• Maximize shared platforms (real-time alerts and UM & CM systems)
• Ensure clear lines of communication

Outcomes
• Increase post-discharge follow up visits
• Decrease avoidable readmissions
• Increase member self-management or enroll in Complex Care Management program
Care Coordination & Care Management Overview

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## Primary Care Case Management vs. Delegated MCO Care Management

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Goals</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home Primary Care Case Management</td>
<td>Coordination of health services for patients under the primary care of the medical home.</td>
<td>Provider responsibility - claims/encounters*</td>
</tr>
<tr>
<td>MCO Care Coordination</td>
<td>Intermittent, task-focused services available to all members of a MCO to maximize use of covered benefits and achieve population health quality targets.</td>
<td>MCO contract responsibility or delegation payment</td>
</tr>
<tr>
<td>MCO Complex Care Management</td>
<td>Intensive, enrollment-based, personalized program for members with high risks or high needs, to stabilize complex health conditions, reduce risks, and utilize the appropriate level of care and benefits.</td>
<td>MCO contract responsibility or delegation payment</td>
</tr>
</tbody>
</table>

*Requires advanced capabilities by delegated provider organizations.*

*Primary care reimbursement covers basic medical home responsibilities e.g. referral coordination with specialists for patient in care; does not cover coordination of full set managed care benefits.*
## Delegated Care Management Entities

<table>
<thead>
<tr>
<th>Entity</th>
<th>Members</th>
<th>Population Served &amp; Model</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan</td>
<td>159,000</td>
<td>Field based team for (M)LTSS and non-(M)LTSS members</td>
<td>HealthChoice: FHP, ACA, ICP, SNC (M)LTSS, DCFS</td>
</tr>
<tr>
<td>Delegated Provider CMEs</td>
<td>40,000</td>
<td>Field &amp; medical-home based team for non-(M)LTSS members at CCH Med Homes</td>
<td>HealthChoice: FHP, ACA, ICP, SNC</td>
</tr>
<tr>
<td></td>
<td>158,000</td>
<td>Medical-home based team for non-(M)LTSS members at MHN ACO Med Homes</td>
<td>HealthChoice: FHP, ACA, ICP, SNC</td>
</tr>
<tr>
<td></td>
<td>38,000</td>
<td>Medical-home based team for non-(M)LTSS members at Access Med Homes</td>
<td>HealthChoice: FHP, ACA, ICP, SNC</td>
</tr>
</tbody>
</table>

Note: Excludes <2500 members assigned to ILS and DSCC, specialized CMEs for (M)LTSS and legacy DSCC participants
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# HFS CM Process Metrics

https://www.illinois.gov/hfs/SiteCollectionDocuments/Q42020QBRReportUpdate.pdf

### New Enrollee Screening and Assessments

<table>
<thead>
<tr>
<th>Percentage of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment</th>
<th>Q3 2019</th>
<th>Q4 2019</th>
<th>Q1 2020</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
<th>met/not met</th>
<th>Threshold: 70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Community Health Plan</td>
<td>25.21%</td>
<td>24.39%</td>
<td>31.72%</td>
<td>41.97%</td>
<td>36.28%</td>
<td>34.99%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CountyCare Health Plan</td>
<td>40.54%</td>
<td>41.46%</td>
<td>41.92%</td>
<td>44.05%</td>
<td>39.90%</td>
<td>43.01%</td>
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</tr>
<tr>
<td>Aetna (IlliniCare Health)</td>
<td>46.01%</td>
<td>46.87%</td>
<td>50.84%</td>
<td>55.02%</td>
<td>47.70%</td>
<td>46.68%</td>
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<tr>
<td>Meridian Health Plan</td>
<td>18.08%</td>
<td>23.63%</td>
<td>35.69%</td>
<td>46.74%</td>
<td>39.82%</td>
<td>39.35%</td>
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<tr>
<td>Molina Healthcare</td>
<td>36.56%</td>
<td>40.15%</td>
<td>47.19%</td>
<td>49.69%</td>
<td>41.52%</td>
<td>42.52%</td>
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</table>

### Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)

<table>
<thead>
<tr>
<th>Percentage of high risk enrollees with an IPoC completed within 90 days after being identified as high risk</th>
<th>Q3 2019</th>
<th>Q4 2019</th>
<th>Q1 2020</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
<th></th>
<th>Threshold: TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Community Health Plan</td>
<td>28.00%</td>
<td>20.75%</td>
<td>13.79%</td>
<td>21.30%</td>
<td>22.36%</td>
<td>26.67%</td>
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<tr>
<td>CountyCare Health Plan</td>
<td>55.83%</td>
<td>54.61%</td>
<td>53.60%</td>
<td>57.28%</td>
<td>61.71%</td>
<td>64.15%</td>
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<tr>
<td>Aetna (IlliniCare Health)</td>
<td>30.55%</td>
<td>30.72%</td>
<td>37.44%</td>
<td>60.79%</td>
<td>66.57%</td>
<td>80.76%</td>
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<tr>
<td>Meridian Health Plan</td>
<td>37.02%</td>
<td>35.27%</td>
<td>23.10%</td>
<td>32.50%</td>
<td>38.32%</td>
<td>48.26%</td>
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<tr>
<td>Molina Healthcare</td>
<td>58.86%</td>
<td>49.10%</td>
<td>42.86%</td>
<td>57.31%</td>
<td>59.20%</td>
<td>50.65%</td>
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</table>

### Enrollee Engagement: Service Plan

<table>
<thead>
<tr>
<th>Percentage of enrollees deemed newly eligible for HCBS Waiver who had a Service Plan within 15 days after the MCO is notified of the enrollees HCBS Waiver eligibility</th>
<th>Q3 2019</th>
<th>Q4 2019</th>
<th>Q1 2020</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
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<th>Threshold: TBD</th>
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<tbody>
<tr>
<td>Blue Cross Community Health Plan</td>
<td>69.99%</td>
<td>65.77%</td>
<td>71.98%</td>
<td>72.30%</td>
<td>73.22%</td>
<td>81.25%</td>
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<tr>
<td>CountyCare Health Plan</td>
<td>52.41%</td>
<td>57.88%</td>
<td>73.82%</td>
<td>77.19%</td>
<td>78.47%</td>
<td>82.24%</td>
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<tr>
<td>Aetna (IlliniCare Health)</td>
<td>76.06%</td>
<td>77.46%</td>
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<td>73.12%</td>
<td>75.79%</td>
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<tr>
<td>Meridian Health Plan</td>
<td>68.89%</td>
<td>73.33%</td>
<td>78.99%</td>
<td>80.77%</td>
<td>79.00%</td>
<td>77.67%</td>
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</tr>
<tr>
<td>Molina Healthcare</td>
<td>70.53%</td>
<td>67.62%</td>
<td>62.16%</td>
<td>73.42%</td>
<td>83.16%</td>
<td>66.67%</td>
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</table>
SFY21 HSAG HCBS Q2 Audit Results

CMS Performance Measure Review (received 4/9/21)

- **Q2 Audit Dates:** 12/7/2020 – 12/9/2020
- **Lookback Period:** 3/1/2020 – 8/31/2020
# Care Management Satisfaction

## 2020 Annual Care Management Satisfaction Survey Overview

- 18 question text message survey
- Sent to random samples of 4,390 members in Care Management
- 186 responses → 4.2% response rate

## Quantitative Results

- 87% satisfied or very satisfied with overall Care Management experience
- 89% reported receiving assistance with a medical visit or condition
- 95% strongly agreed or agreed that Care Manager was polite and treated them with respect

## Qualitative Results

- Emphasized strong relationship with Care Managers and receiving assistance with needed services
- Opportunities include timely and consistent communication with Care Manager and additional assistance with SDOH
Care Management Outcomes

Results from Medical Home Network, CountyCare’s longest-running provider-based CM Program

MHN: Proven care model driving lower utilization & cost in Medicaid

- Risk-adjusted decreased utilization: 36%
- Admissions per 1,000: 27%
- Rehospitalizations: 12%
- ER visits: 11%

...and lower costs: 6%

- Total Expenditures (Claims and Fees): $50.4M
- Over 4 years: $79.3M
- Over 5 years: $15.97 PM/PM

MHN ACO is NCQA Accredited for Case Management with a passing score of 99.6

Increased patient engagement:
- Total HRA completion rate: 86%
- Post-ER follow-up within 7 days: 47%
- Post-hospitalization follow-up within 7 days: 7%
- Increased PCP visits: 10%

Industry accreditations:
- MHN ACO is NCQA Accredited
- HSAG Accredited

Source: Paid claims insured 1/1/19 - 12/31/19 paid through 3/31/20. Represents composite risk adjusted metric comparing the ACO to the external network.

This document is proprietary & confidential. You may not reveal the contents without the express written consent of Medical Home Network.
Care Coordination & Care Management

Overview

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CM Program Strategy

2020 Q1
Transitioned 9k Long-Term Services & Supports members and staff to Health Plan Services (HPS) Dept

2020 Q2
Finalized Plans to transition additional members to HPS & focus CCH Integrated Care/CCC on CCH ACHN patients

2020 Q3
CountyCare membership surge due to pandemic economic impact

2020 Q4
FY21 budgeted positions approved
New office space for CM at Harrison Square
HP CM Ops team launched

2021 Q1
Transitioned 150K members and staff to HPS Dept
RFP for new CM system

2021 Q2
Centralizing TOC Program Shared Services
Acceleration of FY21 hiring

2021 Q3
Expand centralized TOC model
RFP for Member Engagement Partner
ILS contract ends

2021 Q4
New CM System Software goes live
CM Staffing Investments
To service 160,000 members (inclusive of 12,000 LTSS) assigned to Health Plan

<table>
<thead>
<tr>
<th>Type of Staff</th>
<th>Role/Need</th>
<th>Current</th>
<th>Total needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>Directors and Managers of Complex Care Management (LTSS and Non-LTSS)</td>
<td>13</td>
<td>24</td>
</tr>
</tbody>
</table>
| Care Coordination Delivery & Support | Nurses, Social Workers, Specialized Care Coordinators  
• Community Based Care Coordination  
• Transition of Care  
• HCBS & LTC Community Health Workers | 185     | 245          |
| Clinical Operations           | Referral Coordinators, Schedulers, Clerks, Administrative Support         | 15      | 31           |

CCH provides staff for shared services supporting CCC & HP Care Management Teams
## CM System Investments

<table>
<thead>
<tr>
<th><strong>CMIS</strong></th>
<th>CCH Health Research and Solutions Unit (HRSU) developed care management system for CCH (ACHN) empaneled membership</th>
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<tr>
<td></td>
<td>Innovative reporting capability allows for enhanced oversight and monitoring of CCH care management programs</td>
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<td>Ongoing collaboration between Health Plan, CCH, and CMIS teams to leverage unique tools to advance provider-owned health plan goals &amp; opportunities</td>
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<th><strong>Virtual Health</strong></th>
<th>Virtual Health was selected thru RFP from a national pool of software vendors to implement best in class technology support for care management services across multiple lines of business by Q4-2021. The four main drivers of selection:</th>
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<td>1. Technology – best of breed cloud technology</td>
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<td>2. Experience – attained NCQA Pre-Validation for PHM and meets all LTSS NCQA accreditation requirements</td>
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<td>3. National Scope – perspective, expertise, experience</td>
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<td>4. Best Value – offered the best value proposition for Health Plan Services</td>
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CM Program Model – Partnerships

Collaborations that increase use of race, ethnicity and language data and target priority populations

Partnering to advance equity

Providers

- Supergroups of PCPs – increase care coordination
- Community BH Providers (eg NB Consent Decree)

Community Partners & Vendors

- Specialized disease management programs
- Technology platforms (eg State ADT vendor)
- Integrated social service partners (eg Flexible Housing Pool)
CM Program Model – Populations
Priorities based on race, ethnicity and language data and health disparities

Goals

- Evidence-based structural programs by condition, population, social determinant, state designations.
- Strategies with detailed content, consistent quality, and a comprehensive approach toward physical, behavioral, social, and equity attributes.
- Impact population health and wellness, improve chronic condition management, and promote excellence in practice.

Focus areas/examples

- Youths
  - Special Needs Children
  - Children with high behavioral health needs

- Population Health Management
  - Maternal child health
  - COVID prevention
  - Nutrition/food access

- Complex Conditions
  - ESRD
  - Hemophilia
  - HIV

- Institution to Community Living
  - Justice Involved Population
  - Consent Decrees
  - Long-term Care